UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| [redacted] 11TH

CARDWELL, JOHN W

SZCZERBA, ARTHUR J 9061 ADM 7/16/01

DOB 9/01/61 039Y M

0001324092

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

TIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS _____

ALLERGIES: _____

GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

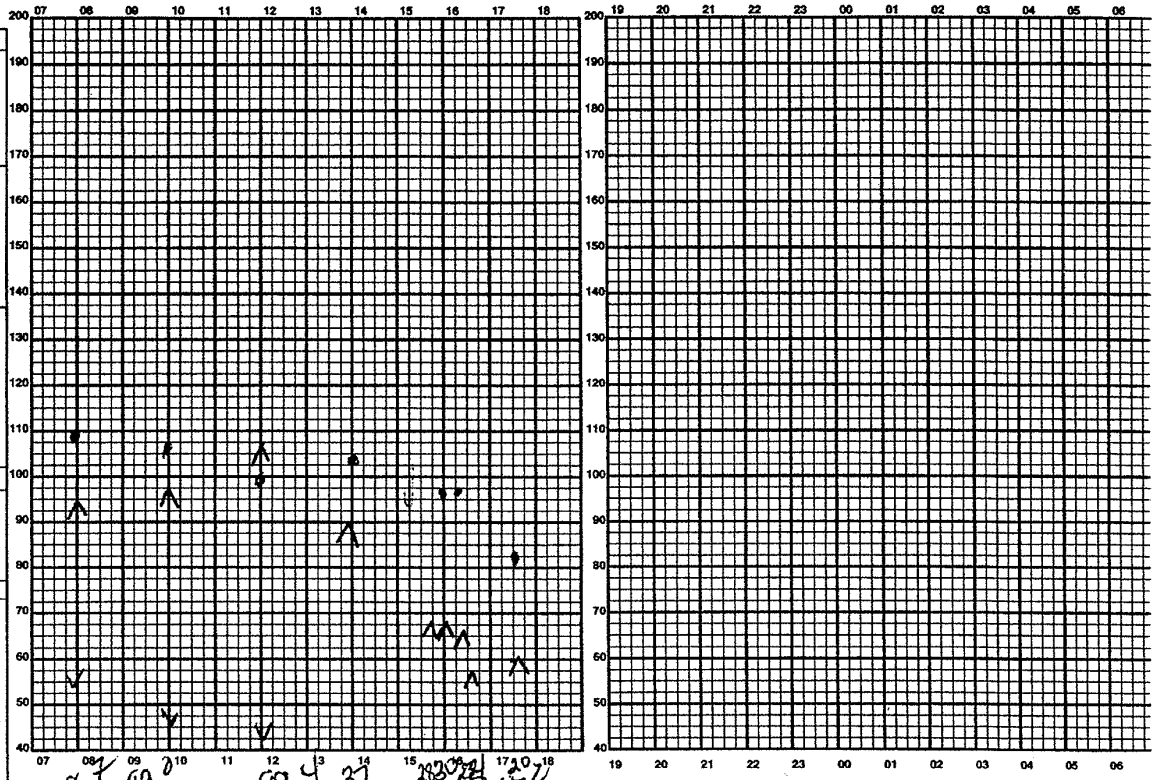
PUPILS

cm: 1 2 3 4 5 6 7 8

EXTREMITIES

STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



HEMODYNAMICS	Respirations / O2 Sat %	22/91	22/91	22/89	22/89	22/90	22/90		
	CO/CI								
	CVP/PCWP								
	PAP								
	SVR/PVR								
NEURO	Eye Opening	1	1	1	1	1			
	Verbal Response	ET	ET	ET	ET	ET			
	Motor Response	1	1	1	1	1			
	Total (≥ 7 indicates coma)	3	3	3	3	3			
	Pupils L	ZNR	NR	NR	NR	NR			
	Pupils R	ZNR	NR	NR	NR	NR			
	Extremities Arm L	Ø	Ø	Ø		Ø			
	Extremities Arm R	Ø	Ø	Ø		Ø			
	Extremities Leg L	Ø	Ø	Ø		Ø			
	Extremities Leg R	Ø	Ø	Ø		Ø			
PULSES	Time	0740							
	Radial L	P3							
	Radial R	P3							
	Dorsalis Pedis L	P1							
	Dorsalis Pedis R	P1							
	Posterior Tibial L	P1							
	Posterior Tibial R	P1							
	TOF	Ø	Ø	Ø					

Form # 8330/03 (REV. 12/99)

DATE: 8/4/01 ROOM# CCU8 1

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UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N| [redacted]

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UNITED REGIONAL HEALTH CARE SYSTEM

Previous Wt.: _____ Current Wt.: _____

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	Soln Site	cc DOSE	TUBE FEEDING	PO	HOURLY SUB TOTAL	RESID‡		URINE ‡	NGT
	Diprivan		Narcan		CEN		NS																
07		6		10		80		20													07		
08																					08		
09																		120 meds			09	5	
10																					10	0	125
11																					11	0	
12																		120 meds			12	0	
13																					13	0	
14																					14	0	200
15																					15	0	
16																					16		
17																					17		
18																					18		
TOTAL																					TOTAL		

TOTAL 12 INTAKE

TOTAL 12 OUTPUT

	TUBE FEEDING	PO	HOURLY SUB TOTAL	RESID‡		URINE ‡	NGT
19					19		
20					20		
21					21		
22					22		
23					23		
00					00		
01					01		
02					02		
03					03		
04					04		
05					05		
06					06		
TOTAL					TOTAL		

TOTAL 12 INTAKE

TOTAL 12 OUTPUT

TOTAL 24° INTAKE | TOTAL 24° OUTPUT | 24° VARIANCE

DATE: 27-6/2 ROOM#

UNITED REGIONAL HEALTH CARE SYSTEM
11TH
36-24-04 IN
CARDWELL, JOHN W
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Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
Bh	Blue RN 7a-7p				

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ **Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management**

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0730	asais	Pt. lying in bed 30° angle c̄ eyes open but comatosed sedated on Diprivan & Norcuron; ds 2x2 covering (R) eyes pupils approx 2 in diameter & non-reactive yellow-white purulent drainage noted on glassy eyed LS "junky" c̄ expiratory wheezes & coarse rhonchi despite vigorous suctioning BS (+) ↑ active Pt is grossly swollen & ascitic 2+ pitting noted to bilateral ankles skin cool to touch Complete assessment done & noted see ✓ list monitor shows SR-ST 100's ectopy noted; armed guards x4 @ bedside — Blue RN
0900		Norcuron stopped @ this time to run Protonix thru a dedicated line; Ø overall Δ's c̄ Pt noted — Bl
1000		repositioned Pt for comfort supported c̄ pillows & mouth care given Ø gag reflex noted Pt has ~~Go~~ purulent yellow drainage from eyes continues to ~~be fixed @ 2~~ pupils NR @ 2 skin cool & dry
1000		foley care done; thick yellow secretions cleaned from penis around foley catheter — Bl
1100		Diprivan stopped @ this time — Bl
1130		Residents here for grand rounds Ø new orders —
1230		unresponsive to all stimuli including deep pain & absent reflexes ~~[illegible]~~ resp 22 in [illegible] & assist c̄ vent — Bl
1400		Dr. Quatchala & J. Dea here to see Pt Ø new orders recd — Bl
1545		BP 68/28 automatic verified by manual pulse

 DATE: 8/4/01 ROOM# 27-68

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

weak & thready Ø other Δ'S noted; Ø urine output noted since 0900 —BC
1600 BP 68/30 Dr Denbo-Sweater here on unit & notified
NS 500ml bolus initiated @ this time ——— [signature]
1745 monitor tracing SR - SB 50-60'S 1748 monitor tracing
agonal 40-50'S 1750 Code 99 called See Code 99 sheet —BC
1803 Pt Pronounced by Dr P. Crappa; allowed guards here to
assume responsibility of body 1805 STA notified of death
awaiting STA Ref to return call ——— [signature]

☐ SEE CONTINUED NURSES' SUMMARY

87-69 4

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See Admission Assessment database for initial admitting assessment

	ASSESSMENT	AM	PM
MENTAL	Alert		
	Cooperative/Uncooperative		
	Anxious/Restless/Agitated		
	Speech Clear/Slurred		
PULMONARY	Breath Sounds: Clear R/L		
	Crackles R/L		
	Wheezes R/L	✓	
	Rhonchi R/L	✓	
	Diminished R/L		
	Absent R/L		
	Resp. Effort: Regular/Irregular	✓	
	Unlabored/Labored	✓	
	Accessory Muscle Use		
	Symmetrical Chest Expansion	✓	
	Denies/Admits SOB or Dyspnea		
	Cough: Productive/Nonproductive	✓	
	Color thick yellow	✓	
	Tracheostomy	✓	
	Cuff up/down	✓	
	Tube secured in place	✓	
	Ambu at bedside	✓	
	ET tube: oral/nasal		
	# cm at teeth/lip		
	size		
CHEST TUBES	CT # 1 site:		
	Suction: # cm H2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 2 site:		
	Suction: # cm H2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 3 site:		
	Suction: # cm H2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 4 site:		
	Suction: # cm H2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		

	ASSESSMENT	AM	PM
CARDIAC	Apical Pulse Regular /Irregular	✓	
	Capillary Refill: < 2 sec/>2 sec	✓	
	Neck Veins: Flat/Distended	✓	
	EKG Rhythm	ST	
	Lead	II	
	EKG Hi/Lo Alarms On at:	150/50	
	Pacer: Temporary/Permanent		
	Insertion Depth (cm)		
	Transvenous/External		
	Epicardial Wires		
	Pulse Generator On/Off		
	Rate		
	MA		
	Demand/Asynchronous		
HEMODYNAMICS	Transducers: Leveled with RA		
	Zeroed & Calibrated		
	1000 U. Heparin		
	500 CC. NS Flush		
	A - Line Site:		
	Proper Wave Form		
	MAP HI/LO Alarms On at		
	Drsg dry & Intact		
	PA Catheter Site:		
	Insertion Depth (cm)		
	Proper Waveform		
	Drsg Dry & Intact		
	CVP Catheter Site:		
	Proper Waveform		
	Drsg Dry & Intact		
	IABP Site:		
	Ratio I:		
	Proper Augmentation		
	Alarm On		
	Drsg Dry & Intact		
SKIN	Intact/Break in Skin Surface*	✓	
	Warm Cool	✓	
	Dry/Clammy/Diaphoretic	✓	
	Pink/Pale (✓ nailbeds/mucous membranes)	✓	
	Cyanotic/Flushed/Jaundiced		
	Edema - Site Generalized 2+		
	+1 +2 +3 P=Pitting Pitting		
GI - GU	Urine Color Amber	✓	
	Clear/Cloudy/Bloody	✓	
	Voids/Foley/CBI	✓	
	Abdomen: Soft/Firm	✓	
	Flat/Distended (grossly)	✓	
	Nontender/Tender		
	Bowel Sounds: Present/Absent	✓	
	Hypoactive/Hyperactive		
	Expels Flatus		
	NGT/PEG (Placement verified)	✓	
	suction/clamped/feeding	✓	
	Urostomy/Ileostomy/Colostomy		
	Stoma Pink/Other		

	ASSESSMENT	AM	PM
SURGICAL	**Incision #1 Site**		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		
	Incision #2 Site		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		
DRAINS	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		
	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		
IV ACCESSES	IV Access: Site (R) TLC	✓	
	Patent	✓	
	IV Access: Site		
	Patent		
	IV Access: Site		
	Patent		
SAFETY	Bed in Low Position	✓	
	Call Light in Reach	✓	
	Side Rails Up: Upper/Full	✓	
	POTENTIAL FOR VIOLENCE	Ø	
ASSESSORS	Assessors Initials	AP BL	PA
	RN SIGNATURE BL RN	AP	PA

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UNITED REGIONAL HEALTH CARE SYSTEM

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ADDRESSOGRAPH

UNITED REGIONAL HEALTH CARE SYSTEM 11TH
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PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.
HOUSE STAFF	ADMITTED	DISCHARGED

07.24-01 Faculty Note

10:15 Pt examined and chart reviewed VS stable still w Tax grade T°. No further changes in mental status. Read further good Notes Dr Lim assessments. I believe his neurological changes and mainly encephalopathic due to liver insufficiency and some related those to head injury. Will continue current management will discuss w Dr Rios about his Abd distension. the prognosis remain guarded now.

527

7-24-01 Late Entry

11:00R Yesterday 7.23-01 at around 13:00R I contacted Dr. Godfrays office regarding Consult for tracheostomy placement. About one hour later I received a call back from Donna RN Dr. Godfrey's office stating that Dr. Godfrey had many emergencies and that he could not place trach. He advised to call Dr. Mercer or general surgeon on call to place trach. Dr. Ulanda notified who advised to wait until today to consult for trach

Ulanda Ulanda, M.D
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ADDRESSOGRAPH

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7/24/01 Renal

U-output = 3400 ml/24h c net bal
+ve 1100 ml on 2 & 6 dl. hydration ok
paralyzed/sedated. Intubated, on vent. ?
encephalopathic? from hepatic failure
BP 131/72 temp 97.0
on CPN. no enteral intake.
Na 146 K 4.2 Cl 108 CO_2 21 glu 195
BUN 26 cr 0.8
Ca 8.4 P 4.8 Mg 2.5
Bili 9.7 AST 115 ALT 74
Art NH4 111
Renal function/electrolyte/fluid bal fair
Little to add from renal viewpoint.
will [illegible] [illegible] - Dr Mrquez [illegible] 27-74[illegible]

PATIENTS PROGRESS NOTES

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7/23/01 PGY-I Note Hos day=(8)

0650 pt is sedated with diprivan = 42 mic, had x2 norcuron has restrain, has jerky tremor mostly in chest & abdomen.
Stool = 1000 cc
VS: Bp= 105/62 T=100.3 P=106 R=20 (CMV) I/O=4796/4700
Heent: PERLA vers slow & slight, NECK=supple Heart: Tachycardia RRR, lung: diffuse ronchi, Fine crackles in R abd: Very distend no BS EXT: edema (+)
lab: Pending
ASST: (1) ARDS (2) shock liver (3) hepatic encephalopathy - maybe (4) h/o HTN, Hep C (+), ETOH, bipolar dis

plan: waiting for tracheostomy, follow atrial anemia

R. Khoshbin

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7/23/01 Neuro

Pt seen + examined
Hx reviewed
Consult dict. # 797561

Imp: ① Heart stroke
currently heavily sedated c Diprivan
② ARDS
③ Hepatic Dysfunction c probable Hepatic encephalopathy
④ Hx of Hepatitis C

Plans: ① review TCDs
② monitor ICP's
③ Continue c current Rx

Thanks. will follow

Copy of OIG case to Litigation Support on 06.26.2013 by scm.
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PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.

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7/23/07
1000 R PGY, notes'

Patient is intubated ē GCS 3. No response to painful stimuli
O2 sat dropped to 87%. Improved ē bagging for 1-2 min.
Exam: - B.P = 122/74 Pulse = 104, T = 100.3°F R/R 28 O2 sat 87%.
I/O = 2501 / 2620.
Chest:- Bilateral ronchi + crepts. Heart: - Regular rythm ē tachycardia
HEENT:- pupils sluggish. Ext:- edema. Abdomen:- distended.
Bowel sounds = sluggish.

A/P : ① ARDS ② shock liver ③ NEC ④ heat stroke
⑤ HTN, ETOH, bipolar disease

Plan:- Patient is on protonix, Lactulose Vancomycin & Flagyl.
Continue same Rx.

[signature]

PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.
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7-23-01 (contd)

AST - 119 ALT - 95 Alkphos 224

T-Bil 9.6 Phos 3.8 Mg 2.3

CBC - WBC 17.7 Hb - 12.7 / Hct - 35.4 Plt - 108K

Discussed: FP Residency program in about going ahead - Trach.

Continue current vent supportive care

C Chakravarthy

7,23,01 PGY-I Note

1440R pt is intubated, sedated with diprivan 42 mic has watery stool = 425cc, on ventilator with Rate = 20

Had EEG,

VS: Bp = 137/68 P = 105 R = 20 (cmv) Te 100.3 O2 Sat = 89% (cmv)

Pt has fasciculations ~~with~~ in chest and abdomen.

HEENT = pupils react very slight and slow, Heart: tachycardia

Lung = ↓ BS in RL lobe, fine crackles in L Lower lobe, Abd: distended

BS ↓ ext edema (+)

ASST: 1) ARDS 2) Shock liver 3) Necrotizing enterocolitis

4) heat stroke 5) h/o HTN, ETOH, bipolar dis

plan: waiting for EEG result, waiting for ENT consult for ~~not~~ tracheostomy

= Koushe

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7-23-01.

Pulmonary:—
overall same, Remain sedate c̄ Diprivan to 75 ug/Kg. y'day 1x had to give norcuron for un controllable tachypnoea. Since then settled down s̄ any episodes of tachypnoea.
Sedate, vent dependant T-98.6°F, afebrile. VSS, CV-RSR, Rate 100-110/mt, BP-nl
u.o.p-good, I/O 4762/3235 cc, last 24 hrs.
y'day Lactulose was fed, has contin diarrhoea.
But, to-day his stool for c-difficile toxin screen reported to be +ve, Levaquin & Cleocin are dc'ed, and started on Flagyl & vanc per NGT.
Pulm. status remain same, still has tendency for tev. Chest - bilateral R>L diffuse coarse rondri. Abd - distended and BS - poor.

Labs:—
ABG, PH 7.41 PCO_2-43 PO_2-69 HCO_3-26 BE+1.9
SaO_2-94% on CMV-20, TV-850 FiO_2-70
Chem. TP 6.2/Alb 2.4, Bun-26 Cr 0.9, Gl-206
K 3.9 Na 141 Cl-106

PATIENTS PROGRESS NOTES

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7/23 Renal

Pt examined. on Diprivan. off nacuron. Low grade temp. vitals stable. BP stable. Urine output adequate +ve balance. edema noted. NGT 50. Nutr 275+950 c- diff +ve. on parenteral nutrition.
CM- 205 BP 92/52 I/O 4762/3235
lungs cnd. Curnosl
Labs: Na 144. K 2.9. Cl 106. Co 29. Bun 26. Cr 0.9
Alb 2.4. Cal 8.7. Bil 9.6. PO4 3.8. Mg 2.3 UA 0.8
An/Plan: ① renal fn remain stable
urine output adeq. +ve balance. Cont
② BP stable lasix fu diuresis
③ BS sliding scale
④ Nutrition - parenteral
⑤ sepsis on Abx
⑥ Alcoholic liver on rx
Plan: Continue current Mx
: See orders

PATIENTS PROGRESS NOTES

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SERVICE	ROOM	CASE NO.

HOUSE STAFF	ADMITTED	DISCHARGED

→ cont

7, 23, 01

decreased distention, ext: edema ⊕

lab: clost dif scree = pos SMA 14 & CBC = pending

ASST: ① shock liver → improving ② heat stroke ③ h/o bipolar dis ④ clost dif pos ⑤ h/o HTN ⑥ h/o ETOH

plan: maybe needs tracheostomy - continue med

F. Koushan
[signature]

7-23-01 Faculty Note
11:20 pt. examined and chart reviewed. N1 shows Afebril. Not responding after musch poralyzing med stop x 24 hrs. still on respirator. CxR look + infiltrates. Ammonia still High. C-Diff toxin (+) Will continue current management. Vancomicin should be give throw the NG Tube. Will discuss w Dr Dean about Flagyl IV. Will consult ENT for tracheostomy and Neurology evaluation

[signature] 323

PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.
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7-22-01 (Contd)

CBC - WBC 15.1K Hb - 11.6 Hct - 32.5 Plt - 98K

Continue present vent support

* pt may need tracheostomy (if doesn't improve soon)

C. Chakinala

7,22,01 ROC Note

2150R pt is intubated with Diprivan 75 mic, no response, CMV R=20 has watery stool trough rectal tube

VS: T=100.4 P=106 R=20 (CMV) BP=104/54

HEENT=PERLA Heart=tachycardia RRR lung=CTA abd: BS=hypoactive ext=+edema

Asst Ep ① shock liver ② heat stroke ③ h/o bipolar d/s ④ h/o HTN

F. Kousha

7,23,01 PGY-I Note HOS=day 2

0520R pt is intubated ~~paralyzed~~ sedated with diprivan 75, no response no active bleeding ~~had~~ stool = 1025

VS: P=104 R=20 (CMV) BP=92/52 T=98 O2 sat (CMV) = 94%

I/O=

HEENT: pupils react slightly to light, sclera = icteric

Heart: tachycardia RRR, Lung = CTA abd: very hypoactive BS

→ cont 27-83

ADDRESSOGRAPH UNITED REGIONAL HEALTH CARE SYSTEM
11TH
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CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

PATIENTS PROGRESS NOTES

FORM NO. 8331/69 REV. (10/95) PRINTED BY STANDARD REGISTER U.S.A.

SERVICE		ROOM	CASE NO.
HOUSE STAFF	ADMITTED		DISCHARGED

7-22-01

Pulmonary :-
Off Norcuron since y'day. on Diprivan infusion around 70-75 mcg/kg rate. no response to calling, moves a little c deep pain when he hyperventilates to 40-50s/mt.
Febrile, T to 101+, Jaundiced. cop-ok
Cor- ST @ 110-120/mt, BP- low nl, still has diarrhea. O_2 sat- 90-91%.
on vent, CMV-20, and assist a little
Chest- bilateral vesicular Bs, Rales (R) lung.
Abd- ⊕ x distended, faint Bs+ (wonder whether he is developing ascites. Ext-⊖
I/O 4197/5250 - 1053 cc last 24 hrs
Cxray. still c (R) lung pneumonia c (L) lung slight congestion.
ABGs PH 7.39 Pco_2-36 Po_2-71 Hco_3-21 BE-3.0
Sao_2-96% on FIo_2-70%
Rpt art Ammonia - 132 umol/L. (112 on 7/21).
Lactulose enema are d/ced - will let GI Know of ↑ ing Ammonia.
Chem. panel Bun-27/cr 0.7 ; Alb 2.8, TP6.1
Gl-169 AST-122 ALT-102 K3.3,
Alk phos 178 , Phos 3.1 mg 2.1

PATIENTS PROGRESS NOTES
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United Regional Health Care System

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SERVICE		ROOM	CASE NO.
HOUSE STAFF	ADMITTED		DISCHARGED

7/22 Renal

Pt examined. on vent. oxygen sats stable. opd nos. low grade temp. vitals stable. BP stable low side. urine output adequate — in balance. fluid 450 / 1300. NGT 200.
consultants comments nos.
cv- 203 BP 91/50 I/O 4197/5200
lungs unch. cyanosis
labs Na 137, K 3.3, Cl 108, CO2 18, BUN 27, cr 0.8, WBC 15.7
alb 2.8, cal 8.7, phos 3.6, mg 2.6, LAP 1.2, Hct 32.4
An/Imp ① renal fn essentially stable
urine output adeq. ...
② Electrolyte stable. low K/ca (from diarrhea)
③ BP stable — low side
④ anemia stable ⑤ ↑ ammonia.
⑥ sepsis on Abx
⑦ Resp fail — on vent
Plan Continue current Rx
watch

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PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.

HOUSE STAFF	ADMITTED	DISCHARGED

→ cont

7/22/01
Asst: ① Shock liver → improving ② heat stroke
③ h/o bipolar dis ④ h/o HTN
~~plan: continue close follow up~~

22 July 2001 Reviewed above c̄ Dr. Kocsis
0746 h. LFT improved except for Serum Bilirubin ↑ to 8.3 mg/dL. Has had pos. output of urine. Pt receiving Lactulose & has diarrhea. Will recheck Art Ammonia in AM. Unsuccessful c̄ IV Dig yesterday; however able to d/c muscle relaxant.
Burross

7-22-01 GE
09:45 Patient having watery stools and this is combination of lactulose per NG Tube and lactulose enemas. will d/c lactulose enemas and give lactulose thru NGT

PATIENTS PROGRESS NOTES
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FORM NO. 8331/69 REV. (10/95) PRINTED BY STANDARD REGISTER U.S.A.

SERVICE	ROOM	CASE NO.
HOUSE STAFF	ADMITTED	DISCHARGED

7/21/01 PGY-1 ROC

1640R S:- Patient is sedated, on ventilator.

O: V.S. B.P: 124/84 mmHg, P: 120, T: 100F, R: 20, O_2 Sat: 94%, I/O: 5913/5295 (+618)

B.S: 205, received 6 U regular insulin

LUNGS: Clear to aus:, abd: tense (NBS), Heart: RRR.

Sedated but had moved arms according to the nurses.

A&P: - Arterial ammonia is 112, hep: C tre.

- His Norcuron is being weaned off, as Dr Chakinala ordered.
- ABGs PH: 7.29, PCO_2: 49.0, PO_2: 66.1, HCO_3: 23.1, SaO_2: 89.7%
- Heart Store, cond: much stable than before.
- Shock liver; liver funct getting better.
- H/O HTN — B.P under control
- ARDS — is on ventilator.
- Will continue to the same plan and follow closely.

Sadaf Anwar

7/22/01 pt is sedated (Dipriven 78 mic) intubated on CMV
650 R Rate = 20

VS: Bp = 90/55 P = 110 R = 20 T = 98° I/O 4197/5250

HEENT: PERLA Heart = RRR tachycardia lung = CTA

abd = soft BS-normoactive ext = (+) edema

Lab: CBC 15.1 > 11.6 < 98 / 32.6 SMA 14 = Pending

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SERVICE		ROOM	CASE NO.
HOUSE STAFF	ADMITTED		DISCHARGED

7-21-01

Pulmonary :—
Still remain sedate c Diprivan @ around 18-20 ug/Kg and Norcuron @ 2 mg/hr.
Not responsive, but stable, T-98.1°F.
VSS, CV - RSR, c rate 110+/mt, BP-120/70s, RR-20 and O2 sat - in 90s. UOP - good, I/O 5913/5295 c last 24hrs. Still on lactulose, rectal output was 600 cc/ last 24 hrs.
Chest - b/l scattered coarse crackles sounds +
Abd - ↓ sounds. Extr - 1+ swelling
Labs :—
ABGs PH 7.31 PCO2 - 44.8 PO2 - 61 HCO3 - 22.1 BE - 4.2
SaO2 - 88 % on 60 % O2, Cmv - 20, Ti - 75
CBC - WBC 14.7 Hb 12.9 Hct - 36.8 plt 64
PT - 12.3 / INR 1.02 PTT 22.5/29-9
Chem - Gl - 208, T. Bil 6.9 D.Bil 3.9
AST - 94 ALT - 138
phos - 2.4 mg 2.0 UA 1.8
GGT - 92
Will f/u, Try cutting down on Norcuron & see whether he would tolerate off of it.
Cxray - worse c ? wet lungs vs Late appearance of aspiration pneumonia - will give a small dose

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SERVICE		ROOM	CASE NO.
HOUSE STAFF	ADMITTED		DISCHARGED

7/21 Renal

Pt examined. sedated & paralyzed on vent. oxygen sats stable but only 60→70%. low grade temp. vitals stable. BP stable. urine output adequate. fluid balance. on parenteral nutrition.
wt 206.8 BP 120/80 I/O 5913/5295
lungs: cnd. CVS: no...
labs: Na 137, K 4.7, Cl 109, CO2 25, BUN 20, cr 0.7
alb 3.2, PO4 2.4, WBC 14.7, Hct 36.6
Ass/Plan: ① renal fxn essentially remains stable - urine output adeq. cont.
② Electrolytes acceptable
③ BP stable
④ anemia stable.
⑤ nutrition - Adequate
⑥ Resp. fail on vent
Recs: Continue current mx
- will

PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.
HOUSE STAFF	ADMITTED	DISCHARGED

7-21-01 GE

10:15

patient being seen for Dr Dean.

WBC 14.700

Hgb 12.9

patient admitted 2° Heat Stroke and consequent hepato cellular injury.

PT 12.3

Liver damage gradually improving

ALT 138

AST ~~229~~ 94

• NO new recommendations

135 | 42

109 | 25

glu ~~288~~

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SERVICE	ROOM	CASE NO.

HOUSE STAFF	ADMITTED	DISCHARGED

→cont

7, 21, 01

HEENT: PERLA Heart = tachycardia RRR lung = some abdominal respiration + CTA abd = normoactive BS soft. ext = no edema

Lab: CBC 14.7 > 12.9 / 36.8 < 64 pt = 12.3 INR = 1.02 PTT = 22.5

SMA 14 = Alb - 3.2 Bun = 20 Ca = 9.2 g = 208 AST = 94

Cl = 109 Alk. phos = 129 NA = 137 CO2 = 25 ALT = 138

Bil = 6.9 GGT = 92

Asst: (1) Heat stroke (2) shock liver (3) ARDS (4) h/o HTN (5) h/o bipolar dis (6) h/o EtOH

plan: close follow up

R. Kousha

21 July 2001 Pt. is showing improvement of 07/46 R. liver fund. tests. On ventilator & sedated c̄ Diprivan + paralized c̄ Norcuron. Platelets improved. Abd distention: lessened B.S. now normal VS stable Abd - essentially neg.

[signature]

PATIENT'S PROGRESS NOTES

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SERVICE	ROOM	CASE NO.
HOUSE STAFF	ADMITTED	DISCHARGED

→ Cont

7/20/01

b/o Bp = 153/109 I discussed the case with Dr. Ravi and we will observe the pt and will check Bp again.

F. Koushan

7/20/01 ROC Note (PGY1-Note)

2030R pt is on Ventilator.

Vs: BP: 144/84 PR: 118 RR: 20 Temp: 99.3°f.

Total 12hr inpt :→ 3115 Total 12 hr outpt : 2445.

Lungs: clear to auscultation

Heart: S1S2 heard. No gallops. No murmurs.

Abdomen: ~~Bs~~ Soft. BS hypoactive. ext: edema.

Informed the BP to Dr. Vogwia.

A&P: Continue the same management.

Pramen.
MD

7/21/01

0650 R

Pt is intubated with CMV R=20 FIO2=60 TV=800

Paralysed & sedated with diprivan = 17mic norcuron = 0.35 mic

VS: Bp=126/86 T=99° P=110 BP = Max diastolic =93

27-92

→ continue

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SERVICE	ROOM	CASE NO.

HOUSE STAFF	ADMITTED	DISCHARGED

7-20-01.

Pulmonary :-
- overall same, still sedated & paralysed
c̄ small dose of norcuron infusion. Has been Afebrile
- Liver function steadily improving.
- T-nl, CVS - RRR c̄ HR 100-110/mt,
BP - nl, U/O - good and I/O 5877/7850 cc
last 24 hrs. O2 Sat - 89-93%
- on SIMV-20 now - as his earlier ABGs
this morning showed PH 7.26 PCO2 - 58 PO2 - 70
HCO3 - 22 BE - 6 Sat 90% on SIMV-15.
(hence Rate was ↑ed to 20).
Chest - b/l vesicular BS+,
CXray - some ↑ infiltration (R) lung.
Will repeat ABGs & readjust vent
CT head scan yesterday - negative.
* Labs - ↓ Phos - was ↑ in 2s

/ C Chakinala

7/20/01 PGY-I Note
1630 R
pt is paralyzed with CMV: R=20 FIO2 = 50%, TV = 800 cc
HEENT: PERLA Heart: tachycardia RRR lung = CTA Abd: BS = hypoactive
ext = no edema
VS BP = 153/109 (at 1500 BP: 140/90) P=118 R=20 (CMV) T=99

27-93
→ Cont

PATIENTS PROGRESS NOTES

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7/20 Hem/Onc

Above entries noted.
No evidence of bleeding.
Platelet 49K. H/H Stable
PT, PTT - Stable
? platelet 2° to Hepatic insufficiency.
Transfuse PRN for count <20K.
No evidence of DIC.
Will sign off. Therapy of
Platelets will gradually rise.

07-20-01
1157 Faculty Note.
Pt. cont. to be on vent. SIMV mode
- sedated & paralysed. Physical findings
& labs outlined in Dr. Kousha note.
Gradual improvement LFT. Platelets - 49,
Renal status stable. Consultant notes
appreciated. Continue present management
& adjust therapy based on clinical Δ.
Head CT - unchanged.

Arthur J. Szczerba

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Lab:- CBC:

11.3 / 15.2 / 42.9 / 113

RBC 4.52, differential WNL,

SMA-14:

Alb - 4.1 glucose - 186 tot bilirubin 1.5
~~BUN - 18~~ AST - 152 (8-40) alk. phosphat - 73
Creatinine - 2.2 ALT - 114 (8-53)
Calcium - 8.7 Total protein . 8.2.

136 | 104 | 186
5.5 | 22 | 18
2.2.

Lytes:

CPK - 280 (45-235)
PT - 13.9 INR - 1.30 PTT 29.3
Drug screen: - TCA screen . > threshold
Urinalysis:-
U color - amber U. nitrate - true
Sp grav - >1.030 RBC - 0-2.
Ketones - trace bacteria - few.
Bilirubin - small.
Urobilinogen >8.0.

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Chest x-ray

EKG: Sinus tachycardia, 148/min. axis 154., broad QRS complexes.

A/P Cardiac markers.

	19:15	2000	1:36.
CKMB	1.8.	2.2	5.3
Myoglobin	~~>~~500	>500	
Troponin I -	0.2	0.3.	.21
	19:16	22:00	
ABG pH -	7.305	~~19:16~~,	7.347
PCO_2 -	31.7		27.8
PO_2 -	225.2.		84.0 m.Hg.
	21:50		19:36.
CPK -	344 (45-235)	,	280

A/P: 1) Heart Stroke

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HOUSE STAFF	ADMITTED	DISCHARGED

7/16/01

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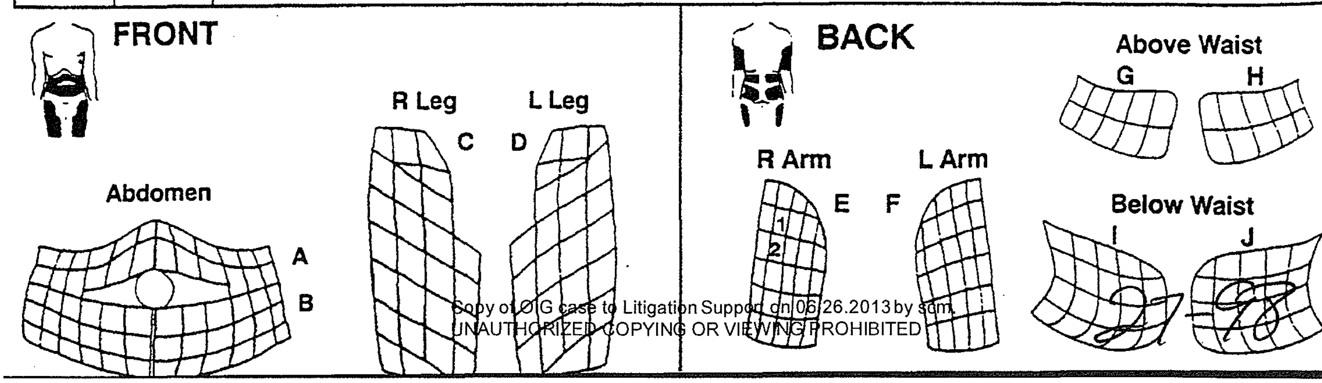
United Regional Health Care System

DIABETIC RECORD

FORM NO. 8331/38 (10/97)

DATE	TIME	INSULIN OR OTHER MEDICATION	SITE/ ROUTE	FSBS	COMMENTS	SIGNATURE / TITLE
7/20/01	0530	Ø coverage	—	222	Skin W/D Reported to Dr. Kolusha	[signature]
7/20/01	1200	Ø coverage	—	210		[signature] RN
7/20/01	1800	Ø coverage	—	171		[signature] RN
7/21/01	0000	3 units Regular insulin	(L) Arm SQ	198	Skin W/D	[signature] RN
7/21/01	0640	3 units Regular insulin	(L) Arm SQ	198	Skin W/D	[signature]
7/21	1210	6 Units		205		[signature] RN
7/21	1800					
7/22	0000	Ø coverage	—	122	Skin W/D	[signature] RN
7/22	0620	6 units Regular insulin SQ	r Arm	211	Skin W/D	[signature] RN
7/22	1200	3 units Reg Ins	(R) arm	194		[signature] RN
7/22	1800	6 units Reg Ins	(L) arm	208		[signature] RN
7/23	0000	6 units Regular	8U RUF	226	Skin W/D	L Steen RN
		NORMAL RANGE BLOOD SUGAR RESULTS = 60 - 130 mg/dl				



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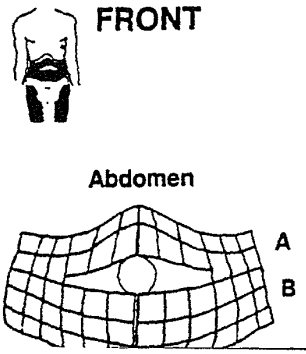
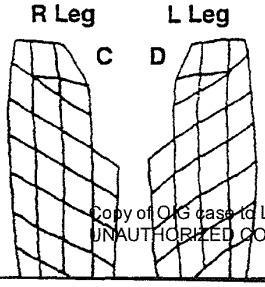
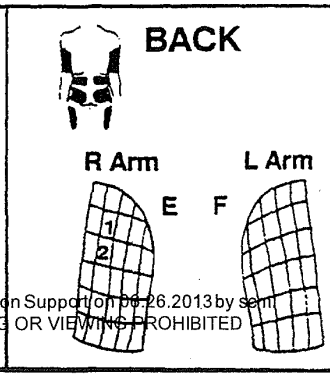
DIABETIC RECORD

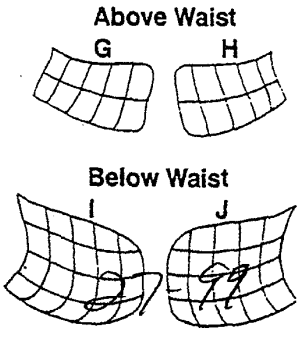
FORM NO. 8331/38 (10/97)

DATE	TIME	INSULIN OR OTHER MEDICATION	SITE/ ROUTE	FSBS	COMMENTS	SIGNATURE / TITLE
7/17/01	2000	Ø		107		E Edwards RN
7/18/01	0000	Ø		111		E Edwards RN
7/18/01	0400	Ø		166		E Edwards RN
7/18/01	1200	Ø		154		S. Hastings
7/18/01	1650	Ø		160		S. Hastings
7/18 01	2015	Ø	—	159	—	O Boos RN
7/19/01	0015	Ø	—	173	—	O Boos RN
7/19/01	0415	Ø	—	182	—	O Boos RN
7/19	0530			163 sma		M Mayfield RN
7/19	1200			201		M Mayfield RN
7/19	1800			175	Skin w/ drsg	S. Allison SN
7/20	0030	—	—	212	Reported to Dr. Kouska @ 0000	R Buselli RN
		NORMAL RANGE BLOOD SUGAR RESULTS = 60 - 130 mg/dl				









UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

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Regional Health System

United Regional Health Care Sys- 11th St
PHONE: 817-720-0211 FAX: 817-720-0877 Wichita Falls, Texas

--- DUPLICATE LABEL ---

Patient Id: 362404 Bag Id: 0001
Name: CARDWELL, JOHN W.
Loc: CCU-08

Order Volume: 2600ml Order Number: 7
Compound Volume: 2600 ml

Hepatasol 8%	-	4.000%
Dextrose 70%	-	10.000%

--Additives--	-Dose-	
SODIUM CHLORIDE	10.00	mEq/liter
SODIUM ACETATE	40.00	mEq/liter
POTASSIUM CHLORIDE	25.00	mEq/liter
POTASSIUM PHOSPHATE	15.00	mEq/liter
CALCIUM GLUCONATE	3.00	mEq/liter
MAGNESIUM SULFATE	3.00	mEq/liter
HEPARIN, SODIUM	1000.0	unit/liter
MULTI-VIT (MVI-12)	10.00	ml
MTE-5 (CONCENTRATE)	3.00	ml
VIT-K (PHYTONADIONE)	1.00	mg

Prep. By: _____ Date 07-25-01 Time 16:15:49
Solution Expires at 20:15 on 07-27-01
Delivery Time To Patient: 07-25-01 2000

12 unit per liter

Regular Insulin 3 units added

CPN. HANG BY 2000. FILTER SIZE (MICRON): 0.2
!!!!! URHCS RULE: HANG CPN BY 2000 EACH DAY !!!!!

Primary Set	Extension	Filter	IVAC Tubing	IVAC	Dial A Flow	Dressing Change	Site Description	Signature

MEDICATION ADDED
PATIENT JM
DRUG Regular Insulin added
AMOUNT 3
ADDED BY [illegible] BASE SOLN
DATE 7/25/01 TIME 2030
START TIME ____ DATE ____ FLOW RATE ____
EXP DATE
THIS LABEL MUST BE AFFIXED TO ALL INFUSION FLUIDS CONTAINING ADDITIONAL MEDICATION.

Place TPN Label Here

27-100

FORM NO. 8331/45 (10/97)

11TH

36-24-04 [N]

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

INTRAVENOUS RECORD

FORM NO. [illegible]/47 REV. (7/97)

NEEDLELESS SYSTEM USED FOR ALL IV's

Date	No. Fluid	Time Started	Time Disc.	Rate	Type and Amt. of Fluid	Medications Added	Dressing	Tubing	Extension Tubing	Iviac	Site Description	Signature
7/21/01		2000		25	Diprivan 100cc premix Tubing d/c'd						Intact	
7/21/01		2200		40	Diprivan 100cc premix						Intact	
7/21/01		2350		45	Diprivan 100cc premix						Intact	
7/22/01		0245		45	Diprivan 100cc premix						Intact	
7/22/01		0450		45	Diprivan 100cc premix						Intact	
7/22/01		0630		45	Diprivan 100cc premix						Intact	

Venipunctures

Date	Time	Description of Needle	Placement	Hep Loc	DC'd	Comment	IV Start Pack Used	Signature

Patient Name At The Bottom.

INTRAVENOUS RECORD

27-101

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

INTRAVENOUS RECORD

FORM NO. 6331/47 REV. (7/97)

NEEDLELESS SYSTEM USED FOR ALL IV's

Date	No. Fluid	Time Started	Time Disc.	Rate	Type and Amt. of Fluid	Medications Added	Dressing	Tubing	Extension Tubing	Iviac	Site Description	Signature
7/20		0100		10	Norcuron 20mg/100cc	—					Intact	@
7/20		0530		10	NS 250cc	ϕ					Intact	@
7/20		0530		3	Diprivan 50cc	ϕ					Intact	@
7/21/01		0000		4.6	Diprivan 50cc	ϕ					Intact	@
7/21		0000		10	Norcuron 20mg/100cc NS	—					Intact	@
7/21/01		0530		4.5	Diprivan 50cc						Intact	@

Venipunctures

Date	Time	Description of Needle	Placement	Hep Loc	DC'd	Comment	IV Start Pack Used	Signature

Patient Name At The Bottom.

27-102

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W ADM 7/16/01
SZCZERBA, ARTHUR J 9061
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

INTRAVENOUS RECORD

FORM NO. 6331/47 REV. (7/97)

NEEDLELESS UNITED REGIONAL HEALTH CARE SYSTEM

Date	No. Fluid	Time Started	Time Disc.	Rate	Type and Amt. of Fluid	Medications Added	Dressing	Tubing	Extension Tubing	Iviac	Site Description	Signature
7/19	0720				Neosynephrine 20mg 1000cc NS →							
7/19	0900				NS 250ml							
7/19					Dopamine premix							
7/19					Diprivan							
1/19					Neosynephrine 20mg/100NS							
7/19		2000		3.3	Diprivan 50cc	ø	—	24D	——		intact	@

Venipunctures

Date	Time	Description of Needle	Placement	Hep Lac	DC'd	Comment	IV Start Pack Used	Signature

Patient Name At The Bottom.

INTRAVENOUS RECORD

27-103

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

INTRAVENOUS RECORD

FORM NO. 8331/47 REV. (7/97)

NEEDLELESS SYSTEM USED FOR ALL IV's

Date	No. Fluid	Time Started	Time Disc.	Rate	Type and Amt. of Fluid	Medications Added	Dressing	Tubing	Extension Tubing	Iviac	Site Description	Signature
7/17					Diprivan 100ml							
7/17					D5 1/2 NS 20K 1 amp KCl/KPhos							
7/18		0300			***Nursing REORDER Request*** CARDWELL, JOHN W (0000)36-24-04 SCCU-08 DEXTROSE 5% IN WATER 1000 mL — 1000 mL; POTASSIUM CHLORIDE 30mEq VIAL — 30 mEq / 15 mL; POTASSIUM PHOSPHATE 4.4mEq/mL INJ — 20 mEq/4.545 ml; SODIUM BICARBONATE 8.4% VIAL — 75 mEq / 75 mL; Order#: 23 Rate: 200 ml/hr							
7/18	?	0915		250cc	***Nursing REORDER Request*** CARDWELL, JOHN W (0000)36-24-04 SCCU-08 DEXTROSE 5% IN WATER 1000 mL — 1000 mL; POTASSIUM CHLORIDE 30mEq VIAL — 30 mEq / 15 mL; POTASSIUM PHOSPHATE 4.4mEq/mL INJ — 20 mEq/4.545 ml; SODIUM BICARBONATE 8.4% VIAL — 75 mEq / 75 mL; Order#: 23 Rate: 200							S. Hodnett
7/18	1200			125cc/hr	***Nursing REORDER Request*** CARDWELL, JOHN W (0000)36-24-04 SCCU-08 DEXTROSE 5% IN WATER 1000 mL — 1000 mL; SODIUM BICARBONATE 8.4% VIAL — 75 mEq / 75 mL; Order#: 45 Rate: 75 ml/hr Freq:							S. Hodnett
7/18	1300			2%	Diprivan							S. Hodnett

Venipunctures

Date	Time	Description of Needle	Placement	Hep Lac	DC'd	Comment	IV Start Pack Used	Signature

Patient Name At The Bottom.

INTRAVENOUS RECORD

27-104

United Regional Health Care System

Hyperalimentation Flow Sheet

Date	Number	Time	Flow Rate Ordered	Primary Set	Extension	Filter	IVAC Tubing	IVAC	Dial A Flow	Dressing Change	Site Description	Signature
7/21/01		1920		✓	✓	✓	✓			✓	Intact	

United Regional Health Care Sys- 11th St Wichita Falls, Texas
PHONE: 817-720-0211 FAX: 817-720-0877

--- DUPLICATE LABEL ---

Patient Id: 362404 Bag Id: 0001
Name: CARDWELL, JOHN W.
Loc: CCU-08

Order Number: 3
Order Volume: 3750ml Compound Volume: 3750 ml

Clinisol 15% (Nova	=	5.000%
Dextrose 70%	=	13.600%
Intralipid 30%	=	3.200%

--Additives--	-Dose-	
SODIUM CHLORIDE	10.00	mEq/liter
SODIUM ACETATE	40.00	mEq/liter
POTASSIUM CHLORIDE	10.00	mEq/liter
POTASSIUM PHOSPHATE	35.00	mEq/liter
CALCIUM GLUCONATE	4.00	mEq/liter
MAGNESIUM SULFATE	6.00	mEq/liter
HEPARIN, SODIUM	1000.0	unit/liter
MULTI-VIT (MVI-12)	10.00	ml
MTE-5 (CONCENTRATE)	3.00	ml
VIT-K (PHYTONADIONE)	1.00	mg

MEDICATION ADDED
PATIENT cardwell TM. 0211-3
DRUG Regular Insulin
AMOUNT 30 u
ADDED BY [illegible] BASE SOLN 0.9
DATE 7/21/01 TIME 1920
START TIME ____ DATE ____ FLOW RATE ____
EXP. DATE
THIS LABEL MUST BE AFFIXED TO ALL INFUSION FLUIDS CONTAINING ADDITIONAL MEDICATION

Prep. By: [signature] Date 07-21-01 Time 14:12:0
Solution Expires at 10:12 on 07-23-01
Delivery Time To Patient: 07-21-01 2000

30 u insulin

CPN. HANG BY 2000. FILTER SIZE (MICRON): 1.2
!!!!! URHCS RULE: HANG CPN BY 2000 EACH DAY !!!!!

Place TPN Label Here

27-105

FORM NO. 8331/45 (10/97)

United Regional Health Care System

Hyperalimentation Flow Sheet

Date	Number	Time	Flow Rate Ordered	Primary Set	Extension	Filter	IVAC Tubing	IVAC	Dial A Flow	Dressing Change	Site Description	Signature
7/20/01	1	19:45	RDuel	✓	✓	✓	✓	—			intact	

United Regional Health Care Sys- 11th St Wichita Falls, Texas
PHONE: 817-720-0211 FAX: 817-720-0877

--- DUPLICATE LABEL ---

Patient Id: 362404 Bag Id: 0001
Name: CARDWELL, JOHN W.
Loc: CCU-08

Order Volume: 3750ml Order Number: 2
Compound Volume: 3750 ml

Clinisol 15% (Nova	=	3.500%
Dextrose 70%	=	8.200% ✓
Intralipid 30%	=	2.000%

--Additives--	-Dose-	
SODIUM CHLORIDE	10.00	mEq/liter
SODIUM ACETATE	40.00	mEq/liter
POTASSIUM CHLORIDE	10.00 ✓	mEq/liter
POTASSIUM PHOSPHATE	35.00 ✓	mEq/liter
CALCIUM GLUCONATE	4.00 ✓	mEq/liter
MAGNESIUM SULFATE	6.00	mEq/liter
HEPARIN, SODIUM	1000.0	unit/liter
MULTI-VIT (MVI-12)	10.00	ml
MTE-5 (CONCENTRATE)	3.00	ml
VIT-K (PHYTONADIONE)	1.00 ✓	mg

MEDICATION ADDED
PATIENT Cardwell BMA 0241-3
DRUG Regular Insulin
AMOUNT 25 Units
ADDED BY [illegible] BASE SOLN D70
DATE 7/20/01 TIME 1945
START TIME ____ DATE ____ FLOW RATE ____
EXP. DATE
THIS LABEL MUST BE AFFIXED TO ALL INFUSION FLUIDS CONTAINING ADDITIONAL MEDICATION

Prep. By: [signature] Date 07-20-01 Time 16:09:41
Solution Expires at 20:09 on 07-22-01
Delivery Time To Patient: 07-20-01 2000

1500 ✓ 3u/Liter Reg Insulin

CPN. HANG BY 2000. FILTER SIZE (MICRON): 1.2
!!!!! URHCS RULE: HANG CPN BY 2000 EACH DAY !!!!!

Place TPN Label Here

97-106

FORM NO. 8331/45 (10/97)

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 [N] 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

Peralimentation Flow Sheet

Dat	Num	Tim	Flow Rate	Primary Set	Extension	Filter	HAC Tubing	IVAC	Dial A Flow	Dressing Change	Site Description	Signature
7/19/01	—	2100									Intact	Lawrence RN

United Regional Health Care Sys- 11th St Wichita Falls, Texas
PHONE: 817-720-0211 FAX: 817-720-0877

--- DUPLICATE LABEL ---

Patient Id: 362404 Bag Id: 0001
Name: CARDWELL, JOHN W.
Loc: CCU-08

Order Number: 1
Order Volume: 3750ml Compound Volume: 3750 ml

Clinisol 15% (Nova	–	3.500%
Dextrose 70%	–	8.200%
Intralipid 30%	–	2.000%

--Additives--	-Dose-	
SODIUM CHLORIDE	10.00	mEq/liter
SODIUM ACETATE	40.00	mEq/liter
POTASSIUM CHLORIDE	40.00	mEq/liter
POTASSIUM PHOSPHATE	25.00	mEq/liter
CALCIUM GLUCONATE	7.00	mEq/liter
MAGNESIUM SULFATE	6.00	mEq/liter
HEPARIN, SODIUM	1000.0	unit/liter
MULTI-VIT (MVI-12)	10.00	ml
MTE-5 (CONCENTRATE)	3.00	ml
VIT-K (PHYTONADIONE)	1.00	mg

Prep. By: CR Date 07-19-01 Time 18:55:30
Solution Expires at 22:55 on 07-21-01
Delivery Time To Patient: 07-19-01 2000

rate: 150

CPN. HANG BY 2000. FILTER SIZE (MICRON): 1.2
!!!!! URHCS RULE: HANG CPN BY 2000 EACH DAY !!!!!

Place TPN Label Here

7-20-01

FORM NO. 3331/45 (10/97)

United Regional Health Care System

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
0001324092

United Regional Health Care Sys- 11th St Wichita Falls, Texas
PHONE: 817-720-0211 FAX: 817-720-0877

Date | Number | Time | Ordered | y Set | sion | er | IVAC Tubing | IVAC | Dial A Flow | Dressing Change | Site Description | Signature

--- DUPLICATE LABEL ---

Patient Id: 362404 Bag Id: 0001
Name: CARDWELL, JOHN W.
Loc: CCU-08

Order Number: 1
Order Volume: 3750ml Compound Volume: 3750 ml

Travasol 10%	-	3.500%
Dextrose 70%	-	5.000%
Intralipid 30%	-	2.000%

--Additives--	-Dose-	
SODIUM CHLORIDE	10.00	mEq/liter
SODIUM ACETATE	40.00	mEq/liter
POTASSIUM CHLORIDE	20.00	mEq/liter
POTASSIUM PHOSPHATE	15.00	mEq/liter
CALCIUM GLUCONATE	5.00	mEq/liter
MAGNESIUM SULFATE	10.00	mEq/liter
HEPARIN, SODIUM	1000.0	unit/liter
MULTI-VIT (MVI-12)	10.00	ml
MTE-5 (CONCENTRATE)	3.00	ml

Prep. By: _____ Date 07-18-01 Time 13:39:11
Solution Expires at 17:39 on 07-20-01
Delivery Time To Patient: 07-18-01 1600

7-18-01 1600

PPN. HANG BY 2000. FILTER SIZE (MICRON): 1.2
!!!!! URHCS RULE: HANG PPN BY 2000 EACH DAY !!!!!

Place TPN Label Here

27-108

FORM NO. 8331/4S (10/97)

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

PATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS _____
ALLERGIES: _____

GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

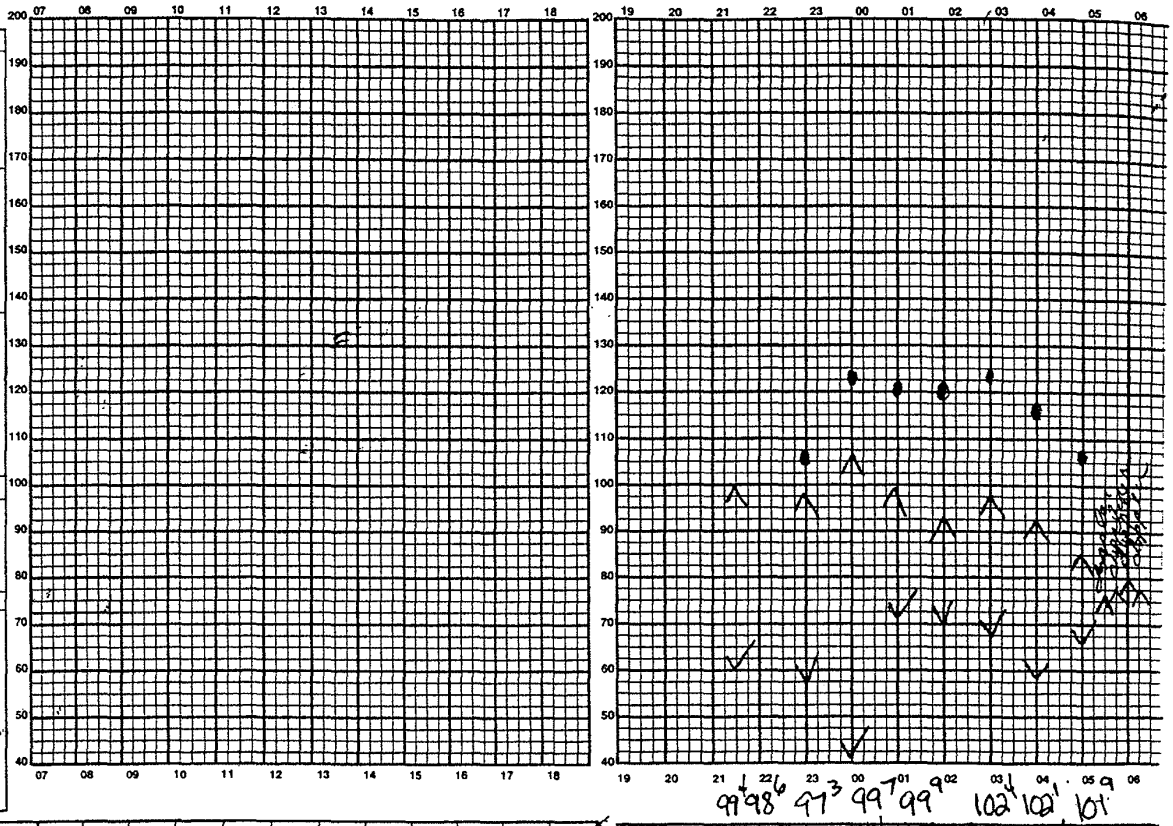
PUPILS

cm: 1 2 3 4 5 6 7 8

EXTREMITIES

STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



HEMODYNAMICS	Respirations																		32	44	45	50	50	44	32	32
	O2 Sat %																		90	98	93	91	89	100	100	98
	CO/CI																									
	CVP/PCWP																									
	PAP																									
	SVR/PVR																									
NUERO	Eye Opening																		1		1				3	
	Verbal Response																		1		4				ETT	
	Motor Response																		4		6				4	
	Total (≥ 7 indicates coma)																		6		11				8	
	Pupils	L																	NRS		R5				SR4	
		R																	NRS		R4				R3	
	Extremities Arm	L																	0		1				1	
		R																	0		1				1	
	Extremities Leg	L																	0		0				1	
		R																	0		1				1	
PULSES	Time																		2130		0100					
	Radial	L																	P2		P2					
		R																	P3		P2					
	Dorsalis Pedis	L																	P1		P1					
		R																	P1		P1					
	Posterior Tibial	L																	P1		P1					
		R																	P1		P1					

DATE: 7-16-01 ROOM# 27-109 ICU 8

36-24-04 [N] 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: _____ Current Wt.: _____

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site														
	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	TUBE FEEDING	PO			HOURLY SUB TOTAL	RESID*		URINE ‡	NGT					
07																		07							
08																		08							
09																		09							
10																		10							
11																		11							
12																		12							
13																		13							
14																		14							
15																		15							
16																		16							
17																		17							
18																		18							
TOTAL																		TOTAL							
	TOTAL 12 INTAKE																	TOTAL 12 OUTPUT							
	NS	NS	Dinner																	Rectal					
19	500	500																19							
20																		20	75						
21																		21							
22																		22	105						
23																		23							
00																		00	140						
01		440																01	115						
02		NS 300																02							
03																		03							
04																		04							
05																		05							
06																		06							
TOTAL	1445	2363	45															TOTAL	700	200	27-110				
	TOTAL 12 INTAKE																	TOTAL 12 OUTPUT			900				
TOTAL 24° INTAKE 3853							TOTAL 24° OUTPUT 900											24° VARIANCE +2653							

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
[illegible]	L Steen RN	[illegible]	L Edwards RN		

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
2030		Received from ER via cot unresponsive, VSS
		See attached sheet for further assessment - [illegible]
2100		Resident's here orders received — [illegible]
2200		pupils slightly reactive, VS + remaining assess
		ment unchanged - had large liquid foul smelling
		stool - occult (neg) - [illegible] — (2300) suctioning large
		amount of bloody phlegm from ET tube & mouth
2330		Dr. Nasser here & other residents. Verbal orders rec'd
		for IVF changes. — L Edwards RN
0045		Pt began coughing on amts of bloody sputum in ETT.
		Residents notified. New orders ~~noted~~ rec'd. L Edwards
0100		Pt suctioned for bloody / pink secretions until clear. Lungs
		are coarse ē rhonchi & crackles. Pt has 1-2+ pitting edema
		— L Edwards RN
0200		Residents here. New order rec'd for labs. L Edwards
0215		New IVF's orders rec'd. NS @ 999cc/hr d/c'd.
		Diprivan [illegible] initiated — L Edwards RN
0415		Pt somewhat restless. Diprivan has helped. Glucose
		on [illegible] 14 57. Called to Dr. Srinivasan. New order
		noted. Also notified of NGT drainage turning dark
		brown coffee ground consistency. — L Edwards RN
0500		BBG - 119. BP 85/46. Rechecked manually - accurate.
		Notified residents. No new orders — L Edwards RN
0615		BP's have been 80 ē Doppler since 0500. Residents
		aware [illegible] order rec'd for [illegible]
		[illegible] spoke ē Dr. Sudarshan. Pt has [illegible]
		[illegible] — L Edwards RN

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M
UNITED REGIONAL HEALTH CARE SYSTEM

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	1021																						
O_2 via	BT																						
L/M or FIO_2	100																						
CMV/SIMV Rate	—																						
Vt	✓																						
CPAP / PEEP	5																						
PSV	20																						
PCV	—																						
DS	Fluf																						

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn																								
CDB																								
TED Care																								
Bath/Shower																					✓			
Mouth Care					✓											✓					✓		✓	
Foley Care																					✓			
Trach Care																								
Oral/Naso/Trach/ETT Suctioning															✓									
Sputum Amount (*Sm/Mod/Lg*)															Lg									
Consistency (*Th = Thick/T =*)															Thk									
Color															Blood									
HOB degree																								

NGT			IV INSERTION				IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site	RAC			Site			By		IV Pump	✓
Size			Gauge	20			Patent			Time		Feed Pump	
By			By	LS			Drsg Applied			Bleeding		Oximeter	✓
Time			Time	2100			By			Hematoma		Ventilator	✓
Placement 'd			Start Kit Used	NO			Time			Site Clean		Temp Pace	
X-Ray			Injection Site	LFS			DRAIN DC'd			Pressure Drsg		SCD/K Ped	✓
To Suction			# Attempts	1			Type			CMS adequate		Bard	
Clamped			IV DC'd				Site			PA CATHETER DC'd		IABP	
Feeding			Site				Drsg Applied			By		Camino	
D/C'd Time			Redness				By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding				Time			Ectopy		Hypo/Hyper	
Size			Drainage				CT DC'd			EXTUBATION		Thermia Unit	✓
Sterile Tech. Used			Infiltration				Site			Hyperoxygenated			
By			Drsg Applied				By M.D.			Suctioned			
Time			By				Drsg Applied			Extubated by			
D/C'd Time			Time				Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		
Aggressive/Assaultive	Time Applied		
	Type: Wrist		
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr		
	per protocol:		
	*Time Discontinued		
Report given to next shift			

27-H2

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

ATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS: FULL
ALLERGIES: NKDA

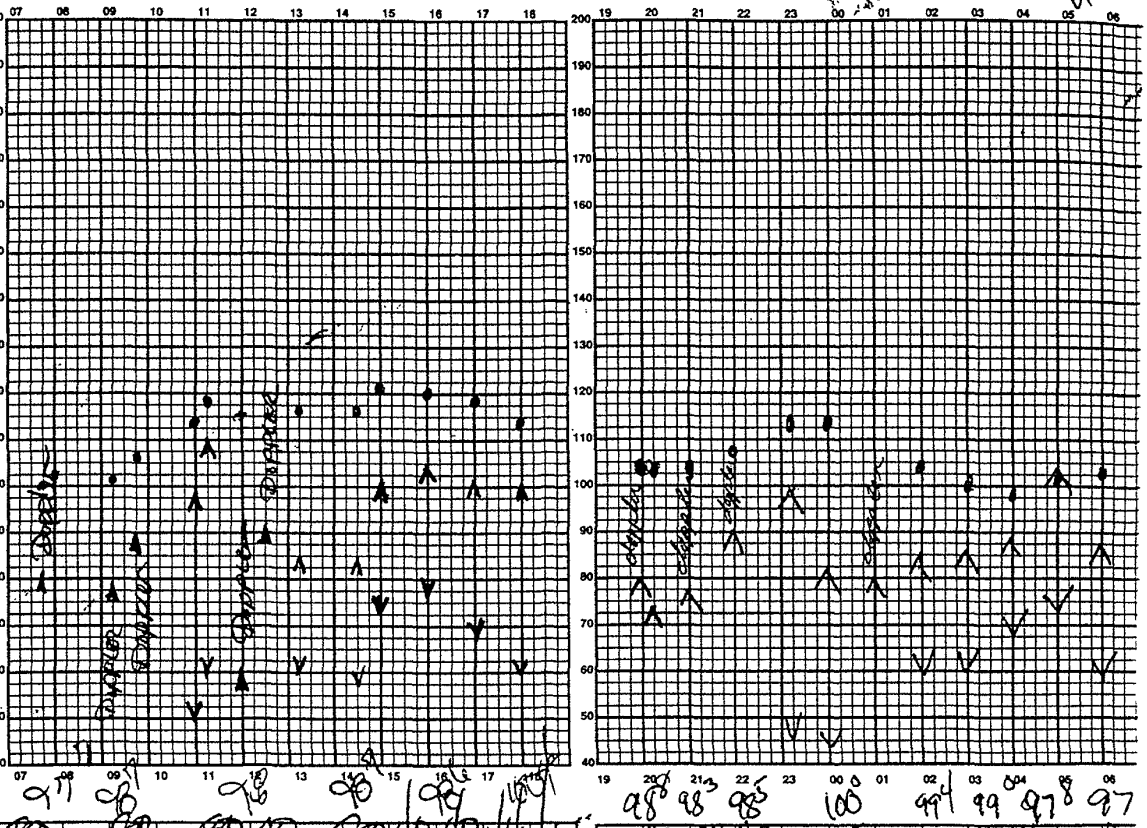
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS: cm 1 2 3 4 5 6 7 8

EXTREMITIES — STRENGTH (Grips): 3 - Strong; 2 - Fair; 1 - Weak; 0 - Absent

PULSES: P = Palpable; D = Doppler; P1 - Weak; P2 - Fair; P3 - Strong; D1 - Monophasic; D2 - Biphasic; D3 - Triphasic



		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
HEMODYNAMICS	Respirations	20	18	20	20	20	20	20	40	40	44	40		42	38	42			15			16	16		16
	O2 Sat %	100	100	98	98	98	98	96	88	92	91	91		98	97	99	92		96			99	100		98
	CO/CI																								
	CVP/PCWP																								
	PAP																								
	SVR/PVR																								
NUERO	Eye Opening	4	4	4	3	4	4	4	4	4	4	4		4											
	Verbal Response	5	5	5	5	5	5	5	5	5	5	5		ET											
	Motor Response	6	6	6	6	6	6	6	6	6	6	6		6											
	Total (≥ 7 indicates coma)	15	15	15	14	15	15	15	15	15	15	15		11											
	Pupils L	3	3	3	3	3	3	3	3	3	3	3		SR4											
	Pupils R	3	3	3	3	3	3	3	3	3	3	3		R3,5											
	Extremities Arm L	3	3	3	3	3	3	3	3	3	3	3		3											
	Extremities Arm R	3	3	3	3	3	3	3	3	3	3	3		3											
	Extremities Leg L	3	3	3	3	3	3	3	3	3	3	3		3											
	Extremities Leg R	3	3	3	3	3	3	3	3	3	3	3		3											
PULSES	Time	0580												2000											
	Radial L	B1												P1											
	Radial R	B1												P1											
	Dorsalis Pedis L													P1											
	Dorsalis Pedis R													P1											
	Posterior Tibial L													P1											
	Posterior Tibial R													P1											

Norcuron gtts

27-113

UNITED REGIONAL HEALTH CARE SYSTEM 11TH
-24-04 |N|
ARDWELL, JOHN W ADM 7/16/01
CZERBA, ARTHUR J 9061
DB 9/01/61 039Y M
0011324092
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: 205.0

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hour	Soln Site (Dip) cc/DOSE	Soln Site (Dop) cc/DOSE	Soln Site (D5W) cc/DOSE	Soln Site (NS 5) cc/DOSE	Soln Site (1/2 NS) cc/DOSE	Soln Site cc/DOSE	Soln Site cc/DOSE	Soln Site cc/DOSE	Soln Site cc/DOSE	Soln Site cc/DOSE	Soln Site	Tube Feeding	PO			Hourly / Sub Total	*Resid*	Hour	Urine ‡	NGT					
07		4.8	2.00															07							
08																		08							
09																		09							
10		4.8																10							
11	[illegible]	10cc																11	1000						
12	41.5	70cc 5.4																12							
13		4.2																13							
14																		14							
15		4.5																15	1700						
16																		16							
17																		17							
18																		18	800						
TOTAL	10	274	238	120	300													TOTAL							

TOTAL 12 INTAKE 3037 — TOTAL 12 OUTPUT 3800

Hour	Dp	Dop	D5W	NS	NS	Noravaph						Tube Feeding (NGT)	PO	Rectal		Hourly / Sub Total	*Resid*	Hour	Urine ‡	NGT	Rectal				
19	84	23 / 6.5	200	10														19							
20		24 / 6.8										60						20	110						
21		26 / 7.4																21	50						
22																		22							
23																		23							
00					250 bolus							60		60				00	230						
01		30 / 8.6				25 / 5mg 15								30				01							
02																		02	135						
03																		03	95						
04																		04							
05						10 / 15												05							
06																		06	195		150				
TOTAL	19	329	287	408	280	94						120		90				TOTAL	865		150				

TOTAL 12 INTAKE 4182 — TOTAL 12 OUTPUT 1015 — 27-114

TOTAL 24° INTAKE 7219 — TOTAL 24° OUTPUT 4815 — 24° VARIANCE (+2404)

2

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
[illegible]	[signature]				
			[signature]		

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ **Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management**

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0730		turns head toward voice no other responce
		noted. (L) pupil is 4mm non reactive (R) 3mm
		reactive. large amount of frothy pink
		sputum suctioned. BP 80 sys t̄ Doppler.
		Skin is cool + clammy. cyanosis noted
		to finger tips + toes. Dr Urquin called
		regarding Plt count of 25 orders received
		[signature]
0915	no	purposeful responce noted - eyes follow movement
	BP 78 Doppler	(R) pupil remains 4mm non reactive. moves
		all extremities. [signature]
0940	Dr	Urquin paged regarding lab results [illegible]
0930		agitated BP 90 ̄c Doppler. weak grip
		noted. Blat. motions 2 fingers on command
		once then no further commands are followed
		Encouraged to relax. [signature]
1030		awake follows commands remains agitated +
		restless. awaiting Dr Chiqqua - rounds. [signature]
1115		agitated BP 110/100 Diprivan started @
		17.1 mcg/kg/min [signature]
1145	Diprivan	↑ to 21.5mcg ̄c good effect. Patient remains
		arousable but calm [signature]
1205	BP	100 ̄c Doppler Diprivan off Dopamine ↑ to ↑cc
		a 5.4mcg/kg
1315		agitated [illegible] follows commands
		Diprivan resumed [illegible] [signature]

3

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W 9061 ADM 7/16/01
SZCZERBA, ARTHUR J 039Y
DOB 9/01/61 M
00011324092

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time																							
O2 via																							
L/M or FIO2																							
CMV/SIMV Rate																							
Vt																							
CPAP / PEEP																							
PSV																							
PCV																							
DS																							

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn																								
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care																								
Foley Care																								
Trach Care																								
Oral/Naso/Trach/ETT Suctioning																						ETT		
Sputum Amount (Sm/Mod/Lg)																						Lg		
Consistency (Th = Thick/T =)																						Th		
Color																						through + bloody		
HOB degree																								

NGT			IV INSERTION			IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT		
Tube Type			Site			Site			By		IV Pump	X	✓
Size			Gauge			Patent			Time		Feed Pump		
By			By			Drsg Applied			Bleeding		Oximeter		✓
Time			Time			By			Hematoma		Ventilator		✓
Placement 'd			Start Kit Used			Time			Site Clean		Temp Pace		
X-Ray			Injection Site			DRAIN DC'd			Pressure Drsg		SCD/K Ped		
To Suction			# Attempts			Type			CMS adequate		Bard		
Clamped			IV DC'd			Site			PA CATHETER DC'd		IABP		
Feeding			Site			Drsg Applied			By		Camino		
D/C'd Time			Redness			By			Time		~~Gormett~~		
FOLEY/STRAIGHT CATH			Bleeding			Time			Ectopy		Hypo/Hyper		✓
Size			Drainage			CT DC'd			EXTUBATION		Thermia Unit		
Sterile Tech. Used			Infiltration			Site			Hyperoxygenated				
By			Drsg Applied			By M.D.			Suctioned				
Time			By			Drsg Applied			Extubated by				
D/C'd Time			Time			Time			Time				

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		
Aggressive/Assaultive	Time Applied		
	Type: Wrist		
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr		
	per protocol:		
	*Time Discontinued		
Report given to next shift			

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UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

PATIENT CARE RECORD - OBSERVATIONS
SPECIALTY CARE
Form # 8330/03 (REV. 12/99)

CODE STATUS Full
ALLERGIES: NKA

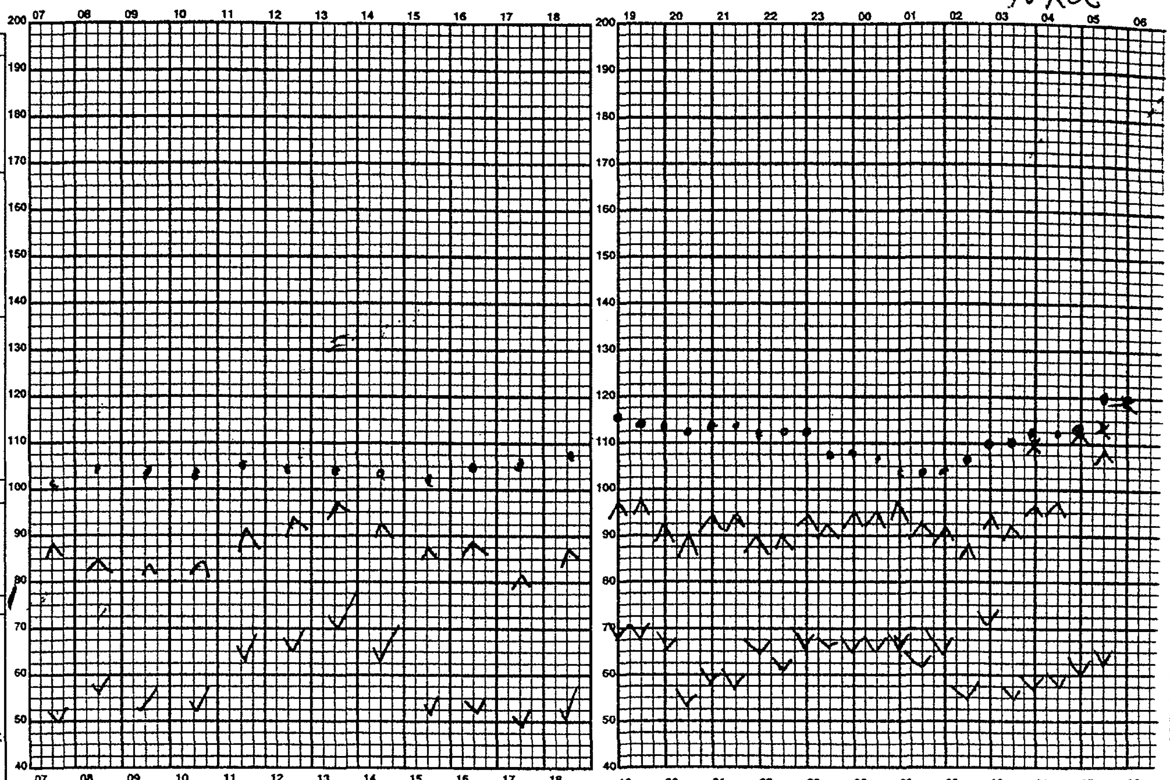
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS (cm) 1 2 3 4 5 6 7 8

EXTREMITIES
STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



Temperatures: 98° 98.6 97 98 97 97 | 97.4 98.4 97.9

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Respirations	16	16	16	16	16	16	16	16	16	16	16	16	17	22	18	20	16	16	18	16	16	16	16	
O2 Sat %	98	98	97	98	97	100	100	100	100	99	98	97	93%	93%	93%	95%	99%	100%	100%	97%	96%	95%	100%	
HEMODYNAMICS CO/CI																								
CVP/PCWP																								
PAP																								
SVR/PVR																								
NUERO Eye Opening	Paralyzed												3					1				1		
Verbal Response	ETT												1 ETT					1				1		
Motor Response	paralyzed												6					1				1		
Total (≥ 7 indicates coma)													10					3				3		
Pupils L	6S					5S			5S				3R											
Pupils R	4S					4S			3S				3R											
Extremities Arm L	0												1											
Arm R	0												1											
Leg L	0																							
Leg R	0																							
PULSES Time	0730												2000											
Radial L	p1												P1											
Radial R	p1												P1											
Dorsalis Pedis L	p1												D1											
Dorsalis Pedis R	p1												D1											
Posterior Tibial L	p1												D1											
Posterior Tibial R	p1												D1											

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Form # 8330/03 (REV. 12/99) DATE: 7-28-01 ROOM# 8

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W

SZCZERBA, ARTHUR J 9061 ADM 7/16/01

DOB 9/01/61 039Y

00011324092 M

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: _____ Current Wt.: 212.7 / 97Kg

*Residuals are not included in the I & O unless discarded

‡ Indicate with 'V' the first void after d/c of Foley

§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	Soln Site / DOSE	TUBE FEEDING	PO	HOURLY / SUB TOTAL	RESID*	URINE ‡	NGT	
07															175		
08															75		
09															75		
10															40		
11															47		
12											60				75		
13															↓		
14															2400		
15															150		
16															200		
17															200		
18											60				200		
TOTAL	1890	312	57	633	116						200		TOTAL 12 INTAKE 3135		3150	300	TOTAL 12 OUTPUT 3750
19															280		
20											30		60		75		
21															80		
22															70		
23																	
00											30		60				
01																	
02																	
03															1145		1400
04											30		60				
05																	
06															400		40
TOTAL	390	41	420	114	1463						90		180		2050	400	1440
													TOTAL 12 INTAKE 2089				TOTAL 12 OUTPUT 3890

TOTAL 24° INTAKE 5222 TOTAL 24° OUTPUT 7640 24° VARIANCE (-1807)

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
SH	Sally Hastings RN				
Oz	Ozinski RN				

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
1900	Oz	Pt	sedated					
0000	Oz	Pt	sedated					
0400	Oz	Pt	sedated					

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0730		Rec'd report, assessed pt, see v/s's for details, updated pt's mom on pt's
		status critical - neuro paralyzed on Norcuron, sedated c Diprivan
		5.9mg IVS (R) & (L) ac & (L) hand, central line ordered by Dr Chak-
		ravarti, anesthesia paged to come insert central line - art line, pls -
		IV ordered by Dr Urquia, no movement by pt - paralyzed, shackled
		@ legs - soft restraints hands - cuffs checked, updated on status -
		no response, oral ET - 8.0 24 @ lip, vent/ed 50% FiO2, CMV - 16, TV - 750,
		suctioned for lg amt brown & [illegible]
		secretions clamped for Lactulose, rectal tube clamped Lactulose, abd
		lg - rounded BS + V, Foley draining amber colored urine, skin warm/dry,
		Foley blanket on - warm & the [illegible], due to pt's [illegible]. S. Has
0830		Dr Urquia updated on condition, 4 quads @ bedside - S. Has
0930		Dr Markowitz paged to update on lab work orders rec'd aware of labs & [illegible] S. Has
1100		Dr Chakravarti here - aware of status - no orders rec'd. S. Has
1130		Dr Forshee inserted central line in (R) subclavian - x-ray verified placement & [illegible]
		[illegible] superior vena cava, IV's moved to (R) Dopamine [illegible] Dopamine to 7mcg. S. Has
1300		[illegible] resident [illegible] Dr Urquia aware of status S. Has
1500		Dr. Kinder here [illegible] aware of status, TPN started @ 125, S. Has
1630		Dr Thatcher here to see - aware of status, no orders rec'd S. Has
1730		mother & sister @ bedside, updated on status - [illegible] S.H
1830		Norcuron off to see pt's response, [illegible] attempted to move head - saved
		[illegible] - no other response, condition remains critical S. Hastings
1900		Report received from Day shift Pt on small amount of Diprivan
		Pt opens eyes slightly on command. Weak hand grips bilat on
		command [illegible] count [illegible]
		Rt lung [illegible] [illegible] & suction, [illegible] [illegible] Doppler
		NG Tube [illegible] BS Hum [illegible] Cont

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time																							
O2 via	72DS																						
L/M or FIO2	50%																						
CMV/SIMV Rate	16																						
Vt	750																						
CPAP / PEEP																							
PSV																							
PCV																							
DS																							

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn													B		B		B		B		B		B	
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care																								
Foley Care																								
Trach Care																								
Oral/Naso/Trach (ET) Suctioning																								
Sputum Amount (Sm/Mod/Lg)																								
Consistency (Th = Thick/T =)																								
Color																								
HOB degree																								
CMV/ROM Tepkenbu													B		B		B		B		B		B	

NGT			IV INSERTION			IV SITE CARE			IABP/A-LINE DC'd			EQUIPMENT		
Tube Type			Site	(R) Subclav		Site			By			IV Pump		✓
Size			Gauge	triple		Patent			Time			Feed Pump		
By			By	Dr Fox		Drsg Applied			Bleeding			Oximeter		✓
Time			Time	1107		By			Hematoma			Ventilator		✓
Placement 'd			Start Kit Used			Time			Site Clean			Temp Pace		
X-Ray			Injection Site	(R) subclav		DRAIN DC'd			Pressure Drsg			SCD/K Ped		
To Suction			# Attempts	1		Type			CMS adequate			Bard		
Clamped			IV DC'd			Site			PA CATHETER DC'd			IABP		
Feeding			Site			Drsg Applied			By			Camino		
D/C'd Time			Redness			By			Time			Geomatt		
FOLEY/STRAIGHT CATH			Bleeding			Time			Ectopy			Hypo/Hyper Thermia Unit		✓
Size			Drainage			CT DC'd			EXTUBATION					
Sterile Tech. Used			Infiltration			Site			Hyperoxygenated					
By			Drsg Applied			By M.D.			Suctioned					
Time			By			Drsg Applied			Extubated by					
D/C'd Time			Time			Time			Time					

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		
Aggressive/Assaultive	Time Applied		
	Type: Wrist	✓	✓
	Vest		
	4 pt.		
✔ Done-Continues	Needs Attended Q 2 hr		
	per protocol:		
	*Time Discontinued		
Report given to next shift			

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UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

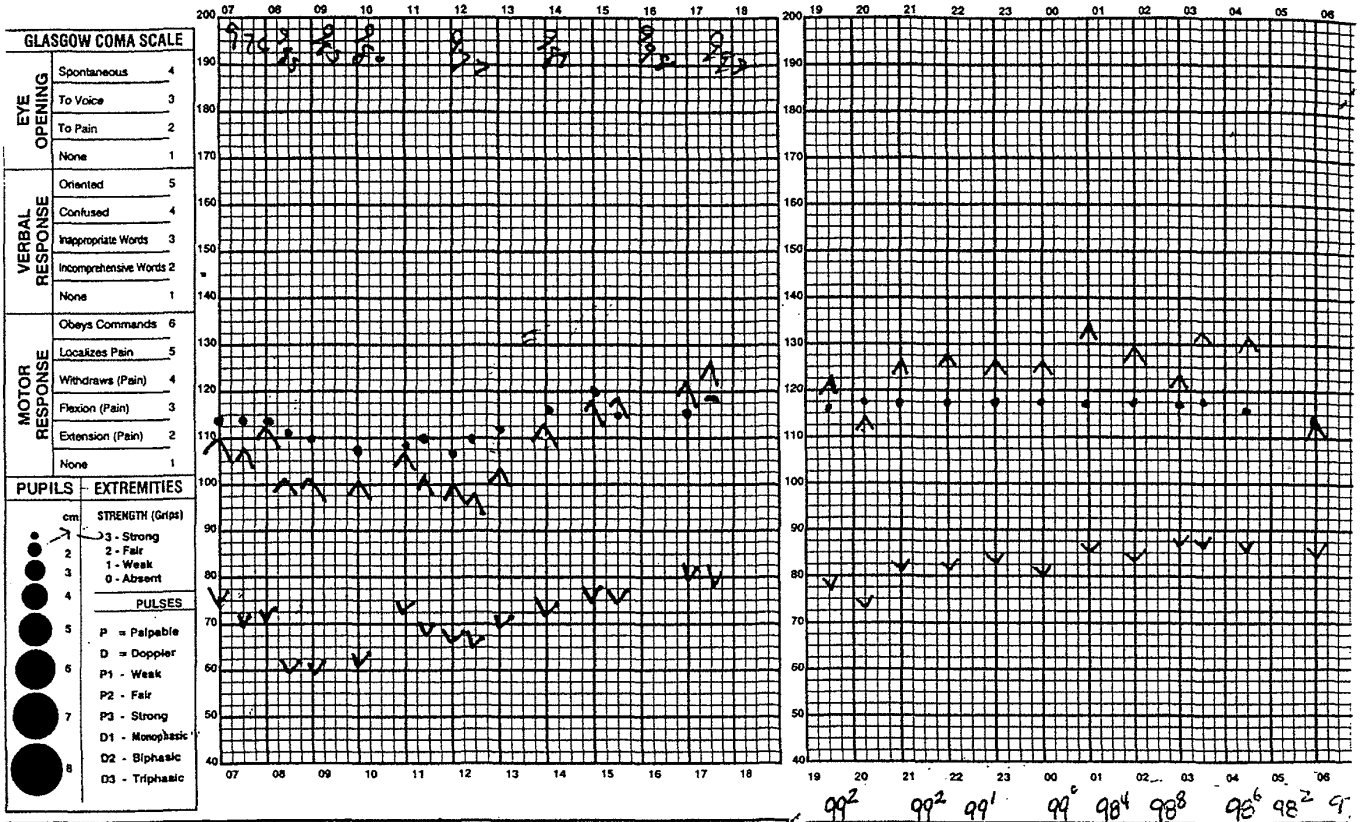
United Regional Health Care System

ATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS Full
ALLERGIES: NKDA



HEMODYNAMICS	Respirations	16	16	16	16	16	16	16	16	16		16	
	O2 Sat %	96	96	97	97	97	97	92	91	91		92	
	CO/CI												
	CVP/PCWP												
	PAP												
	SVR/PVR												
NUERO	Eye Opening	1	1	1	1	1	1	1	1	1	1	1	
	Verbal Response	1	1	1	1	1	1	1	1	1	1	1	
	Motor Response	1	1	1	1	1	1	1	1	1	1	1	
	Total (≥ 7 indicates coma)	3	3	3	3	3	3	3	3	3	3	3	
	Pupils L	R4											
	Pupils R	R4											
	Extremities Arm L	0											
	Extremities Arm R	0											
	Extremities Leg L	0											
	Extremities Leg R	0											
PULSES	Time												
	Radial L	P2											
	Radial R	P2											
	Dorsalis Pedis L	D											
	Dorsalis Pedis R	D											
	Posterior Tibial L	D											
	Posterior Tibial R	D											
	TOF			3/4									

		99²	99²	99¹	99°	98⁴	98⁸	98⁶	98²	9			
		16	16	16	16	16	16	16	16	17	16	16	16
		92	91	91	90	91	90	90	90	91	91	92	91
		1		1	1	1	1	1	1	1	1	1	
		ET-1		ET-1	ETT	ETT	ET-1	ETT	ET-1	ETT	ETT	ETT	ETT
		1		1	1	1	1	1	1	1	1	1	1
		3		3	3	3	3	3	3	3	3	3	3
		SR4		SR4			SR4		SR4			SR4	
		R4		R4			R4		R4			R4	
		0		0			0		0			0	
		0		0			0		0			0	
		0		0			0		0			0	
		0		0			0		0			0	
		A20		2115			0220		0211			0520	
		P2		P2			P2		P2			P2	
		P2		P2			P2		P2			P2	
		P2		P2			P3		P2			P2	
		P2		P2			P3		P2			P2	
		P1		P1			P1		P1			P1	
		P1		P1			P1		P1			P1	

DATE: 7/19/01

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: ______

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hr	Dopamine Premix (cc/dose)	Diprivan (cc/dose)	NS (cc/dose)	Nor awan 20 lbs (cc/dose)	PPN (cc/dose)	1/2 NS (cc/dose)	Soln Site	Soln Site	Soln Site	Soln Site	Tube Feeding	NG	Rectal		Hourly Sub Total	Resid*
07	9.6/2.6	3.3/5.9	10	15/5	125											
08												60	120			
09						100 / 100										
10	30			12.5												
11																
12	25											80	120			
13	20															
14	15															
15	5.0/2.5			10												
16																
17												80	120			
18																
TOTAL	262	470	260	162	549	200						220	360			

TOTAL 12 INTAKE 3075

Hr	Urine ‡	NGT	Rectal			
07						
08	225					
09	175 / 125					
10	200					
11	150		1050			
12	150					
13	100					
14	100					
15	200					
16	275		600			
17	300					
18						
TOTAL	2000	40	1650			

TOTAL 12 OUTPUT 3750

Hr	Dopamine Premix	Diprivan	(Civ) NS	Nimbex	CPN	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Tube Feeding	OGT	RT		Hourly Sub Total	Resid*
19	8.9/2.5	3.3/5.8	10	10/0.35	150 /kg											
20												60	120			
21																
22																
23																
00												30	60			
01																
02																
03																
04				8/0.28								60	120			
05																
06		9/5.2														
TOTAL	108	39	285	120	1800							150	300			

TOTAL 12 INTAKE 2802

Hr	Urine ‡	NGT	RT			
19	250		200			
20						
21	350†					
22						
23	350†					
00	1300		400			
01						
02	350†					
03						
04	350†					
05	350†					
06	1400		400			
TOTAL	2700	100	1300			

TOTAL 12 OUTPUT 4100

TOTAL 24° INTAKE 5877 **TOTAL 24° OUTPUT** 7850 **24° VARIANCE** (-1973) 2